

From the Acting Chief Medical Officer  
Dr Elizabeth Mitchell



Department of  
**Health, Social Services  
and Public Safety**

An Roinn

**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

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Our Ref: HSS(MD)14/2006  
Date: 14<sup>th</sup> July 2006

## HSS(MD)14/2006

To:

Chief Executives, HSS Boards and Trusts  
Directors of Public Health, HSS Boards  
Director of Nursing, HSS Boards  
Directors of Pharmaceutical Services, HSS Boards/Trusts/CSA  
GP Medical Advisers, HSS Boards  
Consultants in Communicable Disease Control, HSS Boards  
All Community Pharmacists  
Medical Directors, HSS Trusts (*for onward distribution to all Consultants*)  
Nursing Directors, HSS Trusts (*for onward distribution to all Community Nurses*)  
All General Practitioners (*for onward distribution to practice staff including practice nurses*)  
Regional Epidemiologist, CDSC (NI)  
Dr P Jackson, Chair, Regional Immunisation Committee

Dear Colleague

### **CHANGES TO THE CHILDHOOD IMMUNISATION PROGRAMME: Further Information**

We are writing to you with further information about changes to the routine Childhood Immunisation Programme. This follows our letter of the 8<sup>th</sup> February 2006 (HSS(MD)2-2006).

From 4<sup>th</sup> September 2006, the following changes will be introduced:

- Pneumococcal vaccine will be introduced to the routine childhood immunisation programme, and the schedule for MenC and Hib vaccines will be modified.
- The new routine schedule given in Annex 1, Table 1 will be introduced. This schedule requires an additional immunisation visit at 12 months of age.
- A pneumococcal vaccination catch-up programme will be carried out for children aged under two years.

The Joint Committee on Vaccination and Immunisation has endorsed these changes.

There are sufficient supplies of pneumococcal vaccine for all children born between 5 September 2004 and 3 June 2005 to be offered vaccination earlier than suggested in Table 3. This flexibility may assist general practices in organising their immunisation clinics.

We recognise the short lead-in time between this letter and the start date. We would encourage those who can implement the programme promptly to do so.

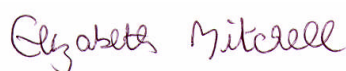
## Practical Arrangements for Introducing The Above Changes

1. HSS Boards and Trusts should liaise with the service providers for their child health information systems to ensure that children are called for appointments.
2. Supplies of the new vaccines will be available from designated hospital pharmacies prior to the start of the new programme on 4<sup>th</sup> September 2006.
3. Designated hospital pharmacies will be able to order supplies of the new vaccines from Castlereagh Pharmaceuticals prior to 4<sup>th</sup> September 2006.
4. Further details on the availability of supplies will be issued by the Regional Pharmaceutical Procurement Service (Tel: 028 90 552386) to designated hospital pharmacies prior to 4<sup>th</sup> September 2006.
5. The packaging of the new vaccines is bulky. General practices and pharmacies need to ensure sufficient fridge space is available to store the new vaccines.
6. National agreement has been reached with the BMA General Practitioners Committee. GPs will be remunerated for the administration of pneumococcal vaccine and the combined Hib/MenC vaccine, and separately for the pneumococcal catch-up programme.
7. Information materials for parents and health professionals will be sent to general practices, health promotion units, community pharmacies and immunisation co-ordinators. They will also be available on the DHSSPS website at: [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk).
8. A national advertising campaign will be run to raise awareness among parents about the new programme.
9. Immunisation co-ordinators (CCDCs) will be able to provide advice to healthcare professionals and HSS Boards and Trusts.

Further details of the changes to the immunisation programme are given in Annex 1, with details of the pneumococcal vaccination catch-up programme given in Annex 2. Table 3 can also be used by general practices to organise and help explain the catch-up programme to parents.

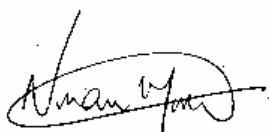
The success of our Childhood Immunisation Programme reflects the commitment and hard work of the entire primary care team. We would like to take this opportunity to thank you for your hard work that will lead to these improvements.

Yours sincerely



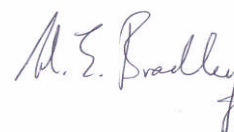
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**Dr E Mitchell**  
Chief Medical Officer (Acting)



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**Dr N Morrow**  
Chief Pharmaceutical Officer



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**Mr M Bradley**  
Chief Nursing Officer

cc Mr A McCormick, Permanent Secretary  
Mr P Simpson, Deputy Secretary, DHSSPS  
Mr D Hill, Deputy Secretary, DHSSPS  
Ms C Jendoubi, Director Primary Care DHSSPS  
Mr A Elliott, Director of Health Development, DHSSPS  
Dr L Doherty, Senior Medical Officer/Consultant Epidemiologist, DHSSPS  
Mr A Charles, Health Protection Team, DHSSPS  
Ms J Moore, Health Protection Team, DHSSPS  
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Prescribing Advisers, Health & Social Services Boards  
Directors of Primary Care, Health & Social Services Boards  
Regional Drug and Poisons Information Service  
Dr J Mairs, Regional Procurement Pharmacist  
Local Health & Social Care Groups – Chairs/Managers  
Dr B Dunn, Chair, GPC, BMA  
Dr B Gaffney, Chief Executive, HPA NI  
Mr P Maguire, Information Office, DHSSPS  
Ms C Baxter, Information Office, DHSSPS  
Members of the RACCDC Regional Immunisation Committee

This letter is available at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk) and also on the DHSSPS Extranet which can be accessed directly at <http://extranet.dhsspsni.gov.uk> or by going through the HPSS Web at <http://www.n-i.nhs.uk> and clicking on DHSSPS.

## THE ROUTINE CHILDHOOD IMMUNISATION PROGRAMME

### 1. Background To The Changes

The background for the changes to the routine childhood immunisation programme is detailed in the letter dated 8 February 2006 HSS(MD)2-2006 DHSSPS weblink:

[http://www.dhsspsni.gov.uk/hss\(md\)2-2006 -  
\\_changes\\_to\\_the\\_childhood\\_immunisation\\_programme-31-1-06.pdf](http://www.dhsspsni.gov.uk/hss(md)2-2006_-_changes_to_the_childhood_immunisation_programme-31-1-06.pdf)

Further information will be available in the factsheets and "The Green Book" new chapters on the website at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk), and on the JCVI website [www.advisorybodies.dh.gov.uk/JCVI/](http://www.advisorybodies.dh.gov.uk/JCVI/).

### 2. Timing

The routine programme will change from 4<sup>th</sup> September 2006. All children starting their immunisation from that date should be offered the new immunisation schedule. The Hib/MenC booster should also be introduced for children aged 12 months of age from that date.

### 3. Routine Childhood Immunisation Schedule

All children starting the immunisation programme at 2 months of age will follow the schedule below (see Table 1):

**Table 1**

When to immunise	What is given	Vaccine and how it is given
Two months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacef)
	Pneumococcal (PCV)	One injection (Prevenar)
Three months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacef)
	Meningitis C (MenC)	One injection (Neisvac C or Meningitec)
Four months old	Diphtheria, tetanus, pertussis, polio and <i>Haemophilus influenzae</i> type b (DTaP/IPV/Hib)	One injection (Pediacef)
	Pneumococcal (PCV)	One injection (Prevenar)
	Meningitis C (MenC)	One injection (Neisvac C or Meningitec)
12 months	<i>Haemophilus influenzae</i> type b, Meningitis C (Hib/MenC)	One injection (Menitorix)
15 months	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
	Pneumococcal (PCV)	One injection (Prevenar)
Three years four months to five years old	Diphtheria, tetanus, pertussis and polio (dTaP/IPV or DTaP/IPV)	One injection (Repevax or Infanrix-IPV)
	Measles, mumps and rubella (MMR)	One injection (Priorix or MMR II)
14 - 18 years old	Tetanus, diphtheria and polio (Td/IPV)	One injection (Revaxis)

It is important that all those involved in immunisations are familiar with the new childhood immunisation schedule (described in Table 1). Changes are:

- the addition of a pneumococcal conjugate vaccine (PCV) at 2, 4 and 15 months of age;
- one dose of MenC vaccine at 3 and at 4 months;
- a booster dose of Hib and MenC vaccine (given as a combined Hib/MenC vaccine) at 12 months of age.

Introducing these changes means that:

- infants will be offered different combinations of vaccines at the 2, 3 and 4 month visits;
- three injections will be offered to infants at 4 months of age;
- a new 12 month vaccination visit will be introduced.

#### **4. Children Aged Over 2 Months At The Start Of The Programme**

There will be a small number of children who will be part-way through their primary vaccination schedule when the changes are introduced. It is important to ensure that these children receive three doses of DTaP/IPV/Hib (Pediace), and at least two doses of MenC (with one dose being given at the 4 month visit).

All children, irrespective of their primary vaccination history, should receive a booster dose of Hib/MenC vaccine at their routine 12 months of age visit in order to ensure long-term protection. There is no Hib/MenC catch-up for children older than 12 months of age at the start of the new programme.

All children aged over 2 months and under 2 years of age will be offered PCV as part of the catch-up campaign (see Annex 2 for details).

#### **5. Children At An Increased Risk Of Pneumococcal Infection**

Some groups of children are at increased risk from pneumococcal infection (see Table 2).

All at-risk children should be offered PCV vaccine according to the schedule for the routine immunisation programme (i.e. at 2, 4 and 15 months of age). In addition, all at-risk children should be offered a single dose of pneumococcal polysaccharide vaccine (PPV) when they are two years of age or over.

##### At-Risk Children Presenting Late For Immunisation

At-risk children who present late for vaccination should be offered 2 doses of PCV<sup>1</sup> before the age of 12 months, and a further dose at 15 months of age. All at-risk children should also be offered a single dose of PPV when they are two years of age or older and at least 2 months after the final dose of PCV.

<sup>1</sup>One month apart if necessary to ensure 2 doses are given before a dose at 15 months.

At-risk children aged over 12 months and under 5 years of age should be offered a single dose of PCV. Please note that children in this age group who have asplenia or splenic dysfunction, or who are immunocompromised, require a second dose of PCV because this group may have a sub-optimal immunological response to the first dose of vaccine. This should be given 2 months after the first dose. They should also be offered a single dose of PPV (if not previously given) when they are two years of age or older (and at least 2 months after the final dose of PCV).

At-risk children presenting for first pneumococcal immunisation aged 5 years and over should be offered a single dose of PPV.

## **6. Children Under Five Years Of Age Who Have Previously Had Invasive Pneumococcal Disease**

All children under 5 years of age who have had invasive pneumococcal disease (IPD), for example pneumococcal meningitis or pneumococcal bacteraemia, should be offered a dose of PCV irrespective of previous vaccination history. Children under 15 months who are unvaccinated or partially vaccinated should complete the recommended PCV immunisation schedule.

These children should be investigated for immunological risk factors to seek a possible treatable condition predisposing them to pneumococcal infection. If they are found to fall into one of the risk groups in table 2, they should receive pneumococcal polysaccharide vaccine after two years of age (and at least 2 months after the final dose of PCV).

All new cases of IPD in children eligible for routine or catch-up PCV will be investigated by the Health Protection Agency (HPA). These cases will be offered antibody testing against each of the 7 vaccine serotypes and advice provided on clinical and immunological investigation (see

[http://www.hpa.org.uk/infections/topics\\_az/pneumococcal/guidelines.htm](http://www.hpa.org.uk/infections/topics_az/pneumococcal/guidelines.htm)

The full surveillance protocol may be found at

[http://www.hpa.org.uk/infections/topics\\_az/pneumococcal/PneumococcalGuidanceSurveillance.htm](http://www.hpa.org.uk/infections/topics_az/pneumococcal/PneumococcalGuidanceSurveillance.htm)

## **7. Vaccination Of Children With Unknown Or Incomplete Vaccination Status**

When a child born in the UK presents with an inadequate or incomplete immunisation record, every effort should be made to clarify what vaccinations they have had. A child who has not completed the routine programme for all vaccines should complete the course, including for pneumococcal vaccination. Children under 12 months of age require two doses of PCV, two months apart, followed by a dose at 15 months. Children aged between 12 and 24 months should be offered a single dose of PCV. Children aged over 24 months do not require vaccination.

Children coming to the UK may not have been offered pneumococcal vaccination previously. Where there is not reliable history of previous immunisation it should be assumed they are unimmunised and the UK recommendation should be followed.

## **8. Pneumococcal Vaccination Catch-Up Programme**

Details of the pneumococcal catch-up programme for all children under two years of age are listed in Annex 2.

## 9. Pharmacy Issues

The following new vaccines will be offered as part of the routine programme.

### ***Pneumococcal Conjugate Vaccine (PCV)***

PCV, brand name Prevenar™, is manufactured by Wyeth Pharmaceuticals.

#### *Presentation:*

Prevenar is presented as a suspension for injection in a pre-filled syringe supplied in a ten syringe pack without needles. The pack size (10 doses) is 144mm x 100mm x 63mm.

During storage a white deposit and clear supernatant can be seen. The vaccine should be shaken well to obtain a homogeneous white suspension and should not be used if it contains any particulate matter once shaken or shows any variation in appearance.

#### *Dosage:*

A single dose of 0.5ml should be given at 2 months and 4 months followed by a third dose as a booster of 0.5ml at 15 months of age.

#### *Administration:*

Vaccines are routinely given intramuscularly into the anterolateral thigh or the upper arm (infants over 1 year of age). This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous injection to reduce the risk of bleeding. The vaccine can be given at the same time as other vaccines such as DTaP/IPV/Hib, MenC and MMR but in a different site.

It is recommended that infants under 1 year of age should be given vaccinations in the anterolateral aspect of the thigh. Where two injections are given in the same thigh, they should be separated by at least 2.5cm and a note be made of which vaccine is given in which site. This should be recorded in the Personal Child Health Record (PCHR – red book) and the child's GP record.

The vaccine must not be mixed with other concurrently administered vaccines.

### ***Hib/MenC Vaccine***

Hib/MenC, brand name Menitorix™ is manufactured by GlaxoSmithKline.

#### *Presentation:*

Menitorix is presented as a one-dose pack containing a vial of white powder and a 0.5ml pre-filled syringe containing a clear colourless solvent. It is supplied with two separate needles - a green needle (21g x 38 mm) for reconstitution and a blue needle (23g x 25 mm) for administration. The pack size (one dose) is 55mm x 133mm x 35mm. Instructions for reconstitution of the vaccine are given at section 7 of the package leaflet.

#### *Dosage:*

A single dose of 0.5ml is to be given as a booster at 12 months of age.

### *Administration:*

Vaccines are routinely given intramuscularly into the anterolateral thigh or upper arm. This is to reduce the risk of localised reactions, which are more common when the vaccine is given subcutaneously. For individuals with a bleeding disorder, however, vaccines should be given by deep subcutaneous injection to reduce the risk of bleeding.

### **Storage of Vaccines**

Vaccines should be stored in the original packaging at +2°C to +8°C and protected from light. All vaccines are sensitive to some extent to heat and cold. Heat speeds up the decline in potency of most vaccines, thus reducing their shelf life. Effectiveness cannot be guaranteed for vaccines unless they have been stored at the correct temperature. Freezing may cause increased reactogenicity and loss of potency for some vaccines. It can also cause hairline cracks in the container, leading to contamination of the contents.

## **10. Reporting of adverse reactions**

Prevenar and Menitorix both carry a black triangle symbol (▼). This is a standard symbol added to the product information of a vaccine/medicine during the early stages of marketing to encourage the reporting of all suspected adverse reactions. If a doctor, nurse, pharmacist or parent suspects that any adverse reaction to Prevenar or Menitorix has occurred, they should report it to the Commission on Human Medicines (CHM) using either the Yellow Card reporting form (e.g. in the BNF), the [www.yellowcard.gov.uk](http://www.yellowcard.gov.uk) website or by telephoning 0808 100 3352.

## **11. Vaccine Supply**

- a. Supplies of the new vaccines will be available from designated hospital pharmacies prior to the start of the new programme on 4<sup>th</sup> September 2006. GPs and clinic staff should liaise closely with their local designated hospital pharmacy department.
- b. Designated hospital pharmacies will be able to order supplies of the new vaccines from Castlereagh Pharmaceuticals prior to 4<sup>th</sup> September 2006.
- c. Further details on the availability of supplies will be issued by the Regional Pharmaceutical Procurement Service (Tel: 028 90 552386) to designated hospital pharmacies prior to 4<sup>th</sup> September 2006.
- d. Surgeries and pharmacies need to ensure sufficient fridge space is available for the new vaccines. Surgeries should only order sufficient stocks prior to the start of the new programme and then draw from their designated hospital pharmacy department.

## **12. Vaccine Stock Management**

Effective management of vaccines throughout the supply chain is an essential part of reducing wastage and maximising efficiency of the programme. Each 1% of the vaccine supplied is worth about £1 million. Even small reductions in vaccine wastage can have a major impact on vaccine supplies and their funding.

General practices are asked to carefully review current stocks of all vaccines and maintain levels of stock sufficient to last no more than 2–4 weeks. General practices with higher stocks of one or more vaccines should start to reduce stock holdings to the target level now, in preparation for the delivery of the new vaccines. Please ensure that any vaccines that are date expired are disposed of following local protocols. Excess supplies of vaccines within their shelf life should be used before new supplies are ordered. General practices are asked to review their holdings of MenC vaccine as the new routine programme only requires two doses of MenC vaccine.

The packaging of Prevenar is significantly larger than that of other vaccine currently being provided. Please ensure sufficient fridge space is available for the new vaccines. Details of the pack sizes are given in Para 9 of this letter.

### **13. Consumables**

Please note that needles will need to be ordered to administer Prevenar. The following product is recommended:

FTR5450 Blue needle 23g x 25 mm (1”)

This product is available on the existing GP pre-printed requisition which when completed should be forwarded in the prepaid envelope as usual, to:

CSA Regional Supplies Service  
Customer Helpline  
77 Boucher Crescent  
Belfast BT12 6HU  
Tel. No. 028 90553443  
Fax. No. 028 90668989

### **14. Child Health Systems**

The introduction of the new routine immunisation schedule will have a significant impact on Child Health Systems. HSS Trusts and the primary care team need to ensure that the Child Health System provider is familiar with the new routine schedule - immunisation co-ordinators may also assist in facilitating the new arrangements.

### **15. Patient Group Directions**

The requirement for Patient Group Directions (PGD) is described in HSS9/2000.

For those general practices that choose to use PGDs, specimen PGDs for Prevenar and Menitorix are available at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk). Boards may wish to tailor these to reflect local needs.

## 16. Funding and Service Arrangements

National agreement has been reached with the BMA – GPC, that GPs will be remunerated for the administration of the Pneumococcal vaccine and the combined Hib/MenC vaccine in the new routine immunisation schedule, and separately for the pneumococcal vaccine catch-up programme.

GPs will be remunerated £15.02 per child for the administration of the pneumococcal vaccinations and the additional vaccination visit at 12 months to administer the combined Hib and MenC vaccine. The Statement of Financial Entitlement will be amended accordingly.

Until the treatment room issue is resolved, the Department will provide funding to HSS Trusts to cover nursing costs for administration of the new routine immunisation schedule.

## 17. Consent

The changes to the vaccine programme will not affect the consent process - consent must be obtained before administration of all vaccines and is not brand specific.

Even if consent has been obtained for the child to be included in the national childhood immunisation programme, health professionals should ensure that consent is in place for each future immunisation. There is no legal requirement for consent to be in writing.

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising, and
- that they are properly informed of the benefits of the new vaccines, the possible side effects and how to manage them.

## 18. Information For Parents And Healthcare Professionals

To support the new changes to the childhood immunisation schedule, DHSSPS and the Health Promotion Agency have produced a range of information resources. New leaflets and factsheets for parents and healthcare professionals will be sent directly to general practices, community pharmacists and health promotion units during August 2006. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses. Resources will also be available to view and download from the DHSSPS website at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk).

The website pages at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk) will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created. These new pages will go live from the 4<sup>th</sup> September.

A national advertising campaign will run to raise awareness among parents about the new programme.

**Table 2 Pneumococcal Clinical Risk Groups for Children**

Note: All children, including those in clinical risk groups, should be offered PCV according to the new routine immunisation schedule. Children in the clinical risk groups listed below, aged 2 months to under 5 years of age should receive 7-valent pneumococcal conjugate vaccine (PCV), according to Annex 1, Paragraph 5. This should be followed by a single dose of 23-valent pneumococcal polysaccharide vaccine when they are 2 years of age or over (and at least two months after the last does of PCV). Children over 5 years of age should receive a single dose of pneumococcal polysaccharide vaccine.

<b>Clinical Risk Group</b>	<b>Examples (<u>decision based on clinical judgement</u>)</b>
Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (eg cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
Chronic renal disease	This includes nephrotic syndrome, chronic renal failure, renal transplantation.
Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis.
Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type 1 diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of $\geq 1\text{mg/kg/day}$ . <i>Some immunocompromised patients may have a suboptimal immunological response to the vaccine.</i>
Individuals with cochlear implants	<i>It is important that immunisation does not delay the cochlear implantation.</i> Where possible, pneumococcal vaccination should be completed at least 2 weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete the course prior to surgery. In this instance, the course should be started at any time prior to surgery. In this instance, the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.
Individuals with cerebrospinal fluid leaks	This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.

## PNEUMOCOCCAL VACCINATION CATCH-UP PROGRAMME

### 1. Timing of Pneumococcal Catch-Up Campaign

The pneumococcal catch-up campaign will start on 4<sup>th</sup> September. Our aim is to ensure that the target cohorts are offered vaccination appropriate for their age within 6 months of the start of the programme.

### 2. The Cohort

Children who will be over 2 months of age and under 2 years of age at the time of introduction will need to be invited to receive pneumococcal vaccine.

Children aged 2 months or under at the time of introduction will be offered pneumococcal vaccine as part of the new routine immunisation programme (see Annex 1). Children over 2 years of age will not be part of the catch-up programme. The risk for children over 2 years of age becoming ill with pneumococcal infection is considerably less than in younger age groups. It is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.

### 3. The Immunisations To Be Offered

The recommended schedule for implementing the programme is summarised in Table 3. The child's date of birth runs down the left-hand side of the table, and the month in which the vaccine is recommended to be given runs along the top of the table.

In summary:

Children born between 3/6/05 and 5/9/04 (i.e. aged over 15 months of age and under 2 years at the start of the programme) should be offered one dose of PCV.

Children born between 4/11/05 and 4/6/05 (i.e. aged 10 months to 15 months at the start of the programme) should be offered one dose of PCV at their routine 15 month visit.

Due to the timescales required for the catch-up programme, children born between 4/12/05 to 3/2/06 (i.e. aged 8 or 9 months at the start of the programme) should be offered 1 dose of PCV at 13 months (see Table 3).

Children born between 3/7/06 and 4/2/06 (i.e. aged over 2 months of age and under 8 months of age at the start of the programme) should be offered two doses of PCV separated by a period of two months. These children should also be offered a further dose at 15 months of age.

The following scenarios help to illustrate the use of the table:

- a) A baby born on 21 June 2006 should be offered PCV at the routine 4 month visit in October, a second dose at an additional 6 month visit in December, and then a booster dose at the scheduled 15 month visit.

- b) A child born on 6 November 2005 should be offered PCV at the scheduled 15 month visit in February.
- c) A child born on 2 April 2005 should be offered one dose of PCV in November<sup>2</sup>.
- d) A child born on 4 September 2004 is not eligible for the vaccine as they are over two years of age when the programme starts. Pneumococcal infections occur less frequently in children aged 2 years and over, and it is likely that pneumococcal infections in all age groups will fall as a result of introduction of the programme in the under two's.
- e) A baby born on 17 July 2006 will not be part of the catch-up programme. This baby will receive pneumococcal vaccination as part of the routine programme.

#### **4. Reporting Of Adverse Reactions**

The reporting of adverse reactions are provided in Annex 1, paragraph 10.

#### **5. Vaccine Supply**

The vaccine supply details are provided in Annex 1, paragraph 11.

#### **6. Vaccine Stock Management**

Managing supplies of vaccine during the pneumococcal catch-up programme presents challenges in vaccine management with which health professionals are familiar. All staff ordering vaccines need to ensure that vaccine wastage is reduced as far as possible by ensuring fridge space is available before ordering and storing the vaccine correctly. Surgeries who find that they have pneumococcal vaccine remaining at the end of the catch-up programme should use it in the routine programme. Vaccine wastage for this catch-up programme should be negligible.

#### **7. Consumables**

The details of the needles required and the way to order them are detailed in Annex 1, paragraph 13.

#### **8. Child Health Systems**

GPs and HSS Trusts need to ensure that their child health system provider is familiar with the timing and role out of the catch-up programme. Immunisation co-ordinators may also facilitate the new arrangements.

#### **9. Patient Group Directions**

The details of Patient Group Directions (PGDs) are given in Annex 1, paragraph 15.

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<sup>2</sup> Please note that there are sufficient supplies of PCV vaccine for all children born between 5/9/04 and 3/6/05 to be offered PCV as soon as it is practically possible after the start of the programme. This will provide general practices with the flexibility to immunise eligible children over a shorter time period.

## 10. Funding And Service Arrangements

National agreement has been reached with the BMA-GPC that GPs will be remunerated separately with regard to implementing the pneumococcal catch-up programme.

GPs will be remunerated £7.51 as an Item of Service payment for each child vaccinated. The Statement of Financial Entitlement will be amended accordingly.

Until the treatment room issue is resolved, the Department will provide funding to HSS Trusts to cover nursing costs in administering the pneumococcal catch-up programme.

## 11. Consent

The details on consent are given in Annex 1, paragraph 17.

## 12. Information for parents and healthcare professionals

Health professionals involved in immunisation must ensure that:

- parents/carers have access to the new information;
- that there is sufficient opportunity for them to discuss any issues arising, and
- that they are properly informed of the benefits of the new vaccines, the possible side effects and how to manage them.

To support the pneumococcal catch-up programme, DHSSPS and the Health Promotion Agency have produced a leaflet and factsheet for parents and healthcare professionals which will be sent directly to GP surgeries, community pharmacists, and health promotion units during August 2006. These resources should be shared with all colleagues involved in giving or advising about immunisation, including health visitors, and practice nurses. Resources will also be available to view and download from the DHSSPS website at [www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk).

The website pages at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk) will be updated to reflect the changes to the programme, and a new section for Hib/MenC immunisation is being created. These new pages will go live from 4<sup>th</sup> September.

A national advertising campaign will run to raise awareness among parents about the new programme.

Table 3

## Pneumococcal Vaccination Catch-Up Table

Recommended schedule for catch-up vaccination from 4 <sup>th</sup> September 2006							
	4 Sept to 3 Oct	4 Oct to 3 Nov	4 Nov to 3 Dec	4 Dec to 3 Jan	4 Jan to 3 Feb	4 Feb to 3 Mar	
Child's date of birth							Child's age at vaccination (months)
5/9/04 to 3/11/04	√						23
4/11/04 to 3/12/04	√						22
4/12/04 to 3/1/05		√					22
4/1/05 to 3/2/05		√					21
4/2/05 to 3/3/05			√				21
4/3/05 to 3/4/05			√				20
4/4/05 to 3/5/05				√			20
4/5/05 to 3/6/05				√			19
4/6/05 to 3/7/05	√						15
4/7/05 to 3/8/05		√					15
4/8/05 to 3/9/05			√				15
4/9/05 to 3/10/05				√			15
4/10/05 to 3/11/05					√		15
4/11/05 to 3/12/05						√	15
4/12/05 to 3/1/06					√		13
4/1/06 to 3/2/06						√	13
4/2/06 to 3/3/06*		√		√			8, 10
4/3/06 to 3/4/06*		√		√			7, 9
4/4/06 to 3/5/06*	√		√				5, 7
4/5/06 to 3/6/06*	√		√				4, 6
4/6/06 to 3/7/06*		√		√			4, 6

## Notes

 Indicates the month in which the child should be offered PCV

\*Children in this age group should receive a booster dose of PCV at 15 months of age and a dose of Hib/MenC at 12 months of age.

Please note that there are sufficient supplies of PCV vaccine for all children born between 5/9/04 and 3/6/05 to be offered PCV as soon as it is practically possible after the start of the programme. This will provide general practices with the flexibility to immunise eligible children over a shorter time period.